THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-02-3672.M2

June 4, 2002

Re: Medical Dispute Resolution
MDR #: M2-02-0618-01
IRO Certificate No.: IRO 5055

Dear

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). Texas Workers' Compensation Commission Rule 133.308 "Medical Dispute Resolution by an Independent Review Organization", effective January 1, 2002, allows an injured employee, a health care provider and an insurance carrier to appeal an adverse determination by requesting an independent review by an IRO.

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a doctor of Chiropractic Medicine.

THE PHYSICIAN REVIEWER OF THIS CASE **AGREES** WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER ON THIS CASE.

I am the Secretary and General Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted. We are simultaneously forwarding copies to the patient, the payor, and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within ten (10) days of your receipt of this decision (28 Tex. Admin. Code 142.5©).
If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of

Proceedings within twenty (20) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you five (5) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on January 24, 2003.

Sincerely,

Secretary & General Counsel

MEDICAL CASE REVIEW

This is for ___. I have reviewed the medical information forwarded to me concerning Case File #M2-02-0618-01, in the area of Chiropractic. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Request for review of denial of chiropractic pain management for 30 visits at 6 hours per day, 5 days per week.
2. Correspondence between the insurance company and other physicians.
3. Notes and evaluations of 2001 and 2002.
4. Notes and evaluations of 1999 and 2000.
5. Biofeedback progress notes.
6. Functional capacity evaluation.
7. Electrodiagnostic study.

B. SUMMARY OF EVENTS:

The patient was apparently injured with a repetitive or cumulative trauma disorder while working as an employee of ___ on or around ___. She was

evaluated by ___, and a trial of conservative therapy was obtained, and the patient eventually wound up with bilateral carpal tunnel surgery and bilateral cubital surgery which, when completed, did not appear to resolve the symptoms.

Further conservative therapy treatments were applied on the neck, upper back, arms, and shoulders that included injections. A series of biofeedback and personal counseling were completed for ten sessions of one hour each, and reported that the patient was learning to cope with the pain. The patient also underwent evaluation and treatment with post-surgical exercise and conditioning and then subsequent work conditioning.

Through all the therapy, surgery, injections, and conditioning with counseling and biofeedback, the patient, at the end of this time, continues to be in similar types of pain, with the nerve conduction and the EMG studies on the upper extremities identifying re-innervation of the left median nerve, and no abnormalities were identified on the right.

C. OPINION:

I AGREE WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER ON THIS CASE.

The specific reasons are that the patient has essentially undergone the elements of the chronic pain management that is being requested, and she did make some mild improvements but, overall, her pain level and coping behavior patterns remain similar. According to many guidelines, including the *Mercy Conference Guidelines*, once an adequate treatment plan has been utilized and the maximum therapeutic benefits have been obtained, further utilization of that therapy is no longer appropriate. I feel that she has essentially completed the activities of chronic pain management. The benefits were short-term, and the patient has returned to modified pain behaviors.

I feel that this patient apparently has reached maximum therapeutic benefit of the procedures applied, and, therefore, further application does not appear to offer additional benefit for the patient.

D. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this

evaluation. My opinion is based on the clinical assessment from the documentation provided.

_____

Date: 3 June 2002